ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD
1740 W. ADAMS ST., SUITE 4600, PHOENIX, ARIZONA 85007
PHONE (602) 364-1PET (1738) FAX (602) 364-1039
VETBOARD.AZ.GOV

received 10/24/19

COMPLAINT INVESTIGATION FORM

If there is an issue with more than one veterinarian please file a separate Complaint Investigation Form for each veterinarian

PLEASE PRINT OR TYPE

FOR OFFICE USE ONLY

Date Received: Oct. 24, 2019 Case Number: 20-44

A. THIS COMPLAINT IS FILED AGAINST THE FOLLOWING:

Name of Veterinarian/CVT: William R Linney, DVM

Premise Name: Linney Surgery & Consulting LLC

Premise Address: Mobil

City: _____ State: AZ Zip Code: _____

Telephone: 602-402-7316

B. INFORMATION REGARDING THE INDIVIDUAL FILING COMPLAINT*:

Name: Megan Benzik

Address: [redacted]

City: [redacted] State: [redacted] Zip Code: [redacted]

Home Telephone: N/A Cell Telephone: [redacted]

**STATE LAW REQUIRES WE HAVE TO DISCLOSE YOUR NAME UNLESS WE CAN SHOW THAT DISCLOSURE WILL RESULT IN SUBSTANTIAL HARM TO YOU, SOMEONE ELSE OR THE PUBLIC PER A.R.S. § 41-1010. IF YOU HAVE REASON TO BELIEVE THAT SUBSTANTIAL HARM WILL RESULT IN DISCLOSURE OF YOUR NAME PLEASE PROVIDE COPIES OF RESTRAINING ORDERS OR OTHER DOCUMENTATION.*

C. **PATIENT INFORMATION (1):**

Name: Selene Benzik

Breed/Species: Blue Merle Australian Shepherd (Dog)

Age: 6 Sex: Female Color: White w/ black spots

PATIENT INFORMATION (2):

Name: _____

Breed/Species: _____

Age: _____ Sex: _____ Color: _____

D. **VETERINARIANS WHO HAVE PROVIDED CARE TO THIS PET FOR THIS ISSUE:**

Please provide the name, address and phone number for each veterinarian.

New Surgeon → Nate Miller DVM, DACVS
5528 N. Nevada Ave
Colorado Springs, CO 80918
*Currently under his care

E. **WITNESS INFORMATION:**

Please provide the name, address and phone number of each witness that has direct knowledge regarding this case.

Sherry Baudreau [redacted] } family
Austin O'Neal [redacted]

ce of 1st Surgery → The Scottsdale Veterinary Clinic [redacted]

Attestation of Person Requesting Investigation

By signing this form, I declare that the information contained herein is true and accurate to the best of my knowledge. Further, I authorize the release of any and all medical records or information necessary to complete the investigation of this case.

Signature: Megan Benik

Date: 10/21/19

F. ALLEGATIONS and/or CONCERNS:

Please provide all information that you feel is relevant to the complaint. This portion must be either typewritten or clearly printed in ink.

Please See [redacted] Following pages for typed explanation + Medical Records

I am going to share a timeline to explain this easier.

December 2018- My pup selene broke her ankle (Luxation of the left calcaneal tarsal joint). I took her to The Scottsdale Veterinary Clinic for initial x-rays. They said that they had a surgeon that was an independent contractor that could perform the surgery, William Linney. I met with him, for the first time, the following week. He explained how he planned to do the surgery, and since I trusted his knowledge, I went forward with it.

January - February 2019- This was the recovery phase. Selene had multiple complications during this time. She formed sores from the splint not being properly sized or on tight enough to prevent moving (I realize this now because of how much better my new surgeon set-up the splint-I can send pictures of the first one upon request). I know sores can occur, and that that is the risk of splinting a dog, but now that I see how a splint SHOULD be on, Im disgusted with how William Linney did this. I never actually saw Dr. Linney throughout the bandage changes. I would drop her off and pick her up. Another thing that happened during this time was when it was finally time to take the splint off of Selene, I picked her up only to find a deep wound on the bottom of her back paw. I called William Linney and he initially told me to just make sure she wasn't licking it. When I realized that the wound was deep enough for bone to show, I brought her in to The Scottsdale Veterinary Clinic for them to take a look. After they examined her, I was informed that she needed to have the big pad on her back foot removed. This was of course an additional charge and I believe this could have been prevented if William Linney had properly examined her leg between splint changes. Since William Linney was not available, she had to be wrapped in a special splint that needed to be changed daily until William Linney was able to make it in. There was a point during this time where I asked William Linney to check her and make sure she was healing right because something seemed off. He insisted that she was healing just fine.

End of february 2019- I brought her in for a routine check up and was told that the pin was starting to come out and that it would need to be removed. So I paid to have this procedure done and I was ALSO told that the pin was completely removed.

March 2019- I was concerned because she had a blister on her heal forming that was starting to ooze a white fluid. The Scottsdale Veterinary Clinic was having problems with William Linney keepig his patient appointments. Selene still had checkups left and they had to cancel a couple times because of William Linney's plans changing. First it was an injury he had, and then it was having to travel, and finally I was told that he was no longer going to be practicing at The Scottsdale Veterinary Clinic. The last visit he had with Selene had to be at a different facility. He examined her heal but did not take any samples or recommend that it needed to be done. He also never mentioned that he had left a piece of wire in her heal. We were sent home with an antibiotic. William Linney also mentioned that it appeared her ankle didn't heal right, but that we would see how it goes.

At the beginning of April, I moved out to Colorado. At this point, Selene was getting around pretty well, but she still had a blister that kept forming on her heel.

October 2019- Selene rebrakes her ankle. I took her to Nate Miller at Canine Orthopedics in Colorado Springs. He started with x-rays. He showed me the xrays and confirmed that there was a random wire left in her heel. He said it didn't appear to have any purpose. He also said that it appeared as if there was still a lot of cartilage left in between the bones that were supposed to fuse together, but that he wouldn't know for sure until he went in. He explained how he does this type of surgery completely different, using a plate and multiple screws as opposed to a pin. He seemed very confident that the surgery would be successful this time since he saw multiple things that should have been done differently. One week later we went through with the surgery. Nate Miller called me afterwards and confirmed that there was a lot of cartilage left in between the bones, and that it was really only a matter of time before her ankle broke again with how the first surgery was done. He also said that he took the wire out of her heel and sent it out to be tested for infection. When the test results came back, Nate Miller called me to inform me that this piece of metal wire that had been left in her heel had a staph infection and that I would have to switch antibiotics. The new antibiotic she is on to treat this is chloramphenicol, and can be harmful to me if I do not take precautions in administering it.

I am currently working on rehabing my pup again and the difference in this is night and day. The splint is smaller and tighter, she seems like she is in less pain, and the medication doses she is on are more reasonable. It's as if William Linney had no idea what he was doing.

I am NOT someone to complain or seek revenge, but this situation has caused me a lot of excess stress, money, and time. I have Lupus (an autoimmune disorder). The stress of rehabbing my pup (twice now), has been hard to manage and has affected my disease activity, not to mention having to take special precautions administering a medication that I never should have had to give her. In addition to this stress, is the stress caused by coming up with the money to afford this surgery to be done TWICE now.

I have attached a full breakdown of charges and medical records from the scottsdale veterinary clinic, where William Linney treated her, along with all the charges and medical records from Nate Miller at Canine Orthopedics in Colorado Springs.

I am filing this complaint so

1. William Linney will be required to undergo proper continuing education on how to properly perform a Partial Tarsal Arthodesis
2. To be reimbursed in full for all the fees I had to pay for the first surgery that was perfromed by William Linney, and all the additional fees I am having to pay currently due to his error. -per Dec 2017 Board Revision

20-44

Selene Benzik – Response to Complaint

(Please also refer to the typed timeline of events)

I provide mobile specialty small animal surgical services to several practices around the Phoenix metro area (Linney Surgery and Consulting). My practice is licensed as a mobile unit and all procedures and exams are performed at licensed veterinary premises, and in concert with those facilities and their staff.

Selene Benzik was referred to me by The Scottsdale Veterinary Clinic (TSVC). I examined Selene and consulted with Megan on December 13th, 2018. I diagnosed a hyperextension with subluxation of the proximal intertarsal joint. The primary instability in this injury is at the calcaneoquartal joint. I recommended partial tarsal arthrodesis of this joint using an established pin and wire technique (Handbook of Small Animal Orthopedics and Fracture Repair, DeCamp, Johnston, et al, 5th edition, pp. 745-748). I discussed the procedure with Megan, including the potential for complications, and surgery was performed later that same day. Proper surgical technique, including high speed burr removal of articular cartilage of the calcaneoquartal joint and application of an autologous bone graft, was followed. Selene recovered well from anesthesia and went home the next day in a splint bandage to protect the healing site.

Selene developed some serious skin complications in the weeks after surgery (please see timeline and medical records). Owner compliance was also an issue, as there are several notes in the records about reminding the owner to properly protect the bandage, use the E-collar, and to ask the client not to place a bandage on Selene's limb on her own. The most serious of the skin complications occurred several days after removal of the last of the post-surgical bandages and appeared to me to be patient self-trauma. There is no documented support for the owner's contention that a deep wound was present on the back of the paw at the time of last bandage removal.

The most severe skin complication (loss of the main pad and adjacent skin) was subsequently well managed by the ER staff at TSVC with debridement and bandaging. A little over a week into this process, the pin used as the primary fixation in this technique loosened and had to be removed. It is my opinion that the cause of the pin loosening was a combination of excess patient activity and inadequate E-collar use leading to soft tissue damage and infection.

Towards the end of February 2019, I noted some instability returning to the calcaneoquartal joint. I had a detailed discussion with the owner (noted in the record) at this time that the complications leading to early pin removal meant that we had an imperfect fusion, and that surgery may have to be repeated if the stability were to fail.

At the time of my last recheck of Selene in April 2019 the tarsus was stable on palpation and there was evidence of a possible skin infection associated with a healing deep wound over the calcaneus. I prescribed a course of antibiotics and asked the owner to keep me posted on Selene's progress.

Several text messages were exchanged between the owner and the Linney Surgery and Consulting cell phone indicating that Selene was doing well, and that the owner was happy. Then in late October we were notified of Selene's second surgery in Colorado and that she was going to file a complaint regarding my care of Selene.

Dr. Miller, the surgeon in Colorado who examined Selene and ultimately performed her revision surgery, apparently noted several things to the owner that led to her filing this complaint. Unfortunately, Dr. Miller never attempted to contact me for clarification on the case, and I have to assume he never read my surgery report from the first procedure. In regard to Dr. Miller's contentions:

1. That there was still a lot of cartilage left in the tarsal joints – Based upon my review of the radiographs from Selene's second surgery in Colorado, Dr. Miller performed an extensive partial tarsal arthrodesis which involves removal of cartilage and subsequent fusion of all of the joints except for the high motion tibio-tarsal joint. As I only performed a partial tarsal arthrodesis of the calcaneoquartal joint, it is logical that there would still be articular cartilage remaining in the talocentral portion of the proximal intertarsal joint.
2. That there was a wire that appeared to have no purpose near the calcaneus – This was the remnant of the orthopedic wire that was used along with the large pin in the calcaneoquartal fusion procedure (again as described in both the textbook and my surgery report).
3. That the portion of wire left near Selene's calcaneus "caused" a staph infection – I'm not sure if this was a contention of Dr. Miller's or an assumption by the owner. Unfortunately, any implant, especially one in the presence of multiple skin complications and infection, can develop a resistant infection. The pin and the larger portion of the wire had been removed during bandage changes and wound care. Had I been able to continue to follow up with Selene and had an obvious sign of a nidus of infection been present (draining tract), I would have recommended removing this remaining portion of wire. As it was, during my last exam of Selene, a small amount of fluid drainage was present associated with a deep wound on the top of the calcaneus. Antibiotics were prescribed and the owner never indicated a continued problem with this area.

It is unfortunate that Selene (and her owner Megan) had to endure the complications that ensued following the first surgery. Complications, however, do not necessarily equate with improper technique or decision making, especially with orthopedic surgery. In this case, a sound decision was made in the choice of surgical technique and the technique was performed properly. Also, many of the complications that arose were likely worsened by client compliance issues as noted in the medical record.

While the owner now has a number of complaints regarding the entire process of Selene's surgery and recovery, these were not indicated as frustrations at all until the board complaint was filed. This is backed up by the text messages exchanged during early 2019. Regarding the owner's assertions that bandaging was done improperly, Selene had only developed mild sores during the initial post-op period. Regarding her assertion that she never saw me, as noted in the medical record I performed several of Selene's rechecks and as anyone who has used a mobile surgery service knows, the post-op management is a shared responsibility (managed well by the TSVC staff and doctors in my opinion). I also never charged anything after the initial surgery fee for my time in helping to manage Selene's recovery. I don't understand the assertion that TSVC was having trouble with me keeping my appointments. I had to take several weeks off for a back injury during this time but otherwise I was not aware of any issues getting Selene scheduled for follow-up.

I am happy to answer any further questions regarding Selene's surgery and subsequent care. Thank you.

Sincerely,

William R. Linney, DVM

Diplomate, American College of Veterinary Surgeons – Small Animal

DOUGLAS A. DUCEY
- GOVERNOR -

VICTORIA WHITMORE
- EXECUTIVE DIRECTOR -

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INVESTIGATIVE COMMITTEE REPORT

TO: Arizona State Veterinary Medical Examining Board

FROM: PM Investigative Committee: Adam Almaraz - Chair
Amrit Rai, DVM
Cameron Dow, DVM
William Hamilton
Brian Sidaway, DVM

STAFF PRESENT: Tracy A. Riendeau, CVT – Investigations
Dawn Halbrook, Compliance Specialist
Mary D. Williams, Assistant Attorney General

RE: Case: 20-44
Complainant(s): Megan Benzik
Respondent(s): William Linney, DVM (License: 4422)

SUMMARY:
Complaint Received at Board Office: 10/24/19
Committee Discussion: 1/7/20 and 2/4/20
Board IIR: 3/18/20

APPLICABLE STATUTES AND RULES:
Laws as Amended August 2018 (Lime Green); Rules as Revised September 2013 (Yellow)

On December 13, 2018, "Selene," a 5-year-old female Australian Shepherd was presented to Respondent for a partial tarsal arthrodesis of the left intertarsal joint. The procedure was performed and the dog was discharged the following day with a splint.

The dog developed skin complications following surgery and at one point lost the main pad and adjacent skin that was managed with debridement and bandaging.

In February 2019, Respondent noted some instability returning to the calcaneoquartal joint which led to the early pin removal and imperfect fusion. Complainant was warned that surgery may need to be repeated if the stability failed.

On October 10, 2019, the dog was presented to Dr. Miller at Colorado Canine Orthopedics & Rehab due to the dog refusing to use the left rear limb and periodic drainage from small sores on the same limb. It was determined that the previous arthrodesis failed. Dr. Miller performed a revision surgery with cartilage debridement, grafting and plate placement.

Complainant was noticed and appeared telephonically on 1/7/20; and was available telephonically on 2/4/20. Respondent was noticed and did not appear on 1/7/20; he was noticed and appeared telephonically on 2/4/20.
Consulting Veterinarian, Nate Miller, DVM, was noticed and appeared telephonically on 2/4/20.

The Committee reviewed medical records, testimony, and other documentation as described below:

- Complainant(s) narrative: *Megan Benzik*
- Respondent(s) narrative/medical record: *William Linney, DVM*
- Consulting Veterinarian(s) narrative/medical records: *Nate Miller, DVM – Colorado Orthopedist*

PROPOSED 'FINDINGS of FACT':

1. On December 10, 2018, the dog was presented to The Scottsdale Veterinary Clinic (TSVC) due to non-weight bearing on the left hind leg after twisting leg playing Frisbee. The dog was examined; radiographs were performed and revealed luxation proximal left intertarsal joint at the plantar and lateral aspect with mineral fragmentation/avulsion fracture fragments. It was recommended Complainant consult with a surgeon, Respondent, and the dog was discharged with Carprofen and Tramadol.

2. On December 13, 2018, Complainant presented the dog to Respondent for a surgical consult after injuring the left rear leg playing Frisbee. The dog was prescribed Tramadol and Carprofen – Complainant had not started the Carprofen at that time. Upon exam, the dog had a weight = 49.4 pounds, a temperature = 102 degrees, a heart rate = 90bpm and a respiration rate = 90rpm. Respondent noted the dog had microphthalmia to the left eye and was deaf. The dog was carrying the left hind limb consistently during ambulation and kept it lifted at rest. Respondent noted instability at the level of an intertarsal joint. No other abnormalities seen.

3. Respondent reviewed the radiographs taken on 12/10/18 and noted a subluxation of the proximal intertarsal joint with marked gapping of the caudal surface and loss of normal joint interaction. He felt the only treatment for this condition was fusion of the affected joint as the fibrous tissues were not capable of healing. Partial tarsal arthrodesis was recommended with a fair prognosis; the dog's active personality would need to be controlled during the healing process.

4. Respondent discussed the surgical procedure including potential risks – failure, infection, etc. An estimate was provided to Complainant which was approved to be performed that day. Blood work was performed and revealed the dog was a surgical candidate; an IV catheter was placed and the dog was started on a liter of Plasmalyte fluids IV.

5. The dog was administered the following:
   a. Butorphanol 10mg/mL, 0.90 (route unknown);
   b. Dexdomitor 0.5mg/mL, 0.50 (route unknown);
   c. Ketamine 100mg/mL, 0.18 (route unknown);
   d. Propofol 10mg/mL, 10 (route unknown); and
   e. Cerenia 10mg/mL, 2.50 (route unknown).

6. Respondent performed a partial tarsal arthrodesis on the dog – A caudo-lateral approach

was made to the calcaneus and tarsal joints through an incision extending from the proximal extent of the calcaneus to several cms distal to the tarsal metatarsal joint. A combination of periosteal elevation and sharp dissection was used to clear the caudal surfaces of the calcaneus, tarsal bones, and proximal aspect of metatarsal bones. The proximal intertarsal joint was exposed and the cartilage surfaces were burred away. After pre-drilling, a large IM pin was passed down the length of the calcaneus, across the proximal intertarsal joint, and into the tarsal/metatarsal bones below while holding the distal limb in alignment and reduction. An autologous bone graft was harvested from the proximal tibia through a small stab incision, and it was placed into the proximal intertarsal joint space. A hole was drilled across the calcaneus and an orthopedic wire was passed and secured via a figure of eight pattern over the proximal extent of the protruding pin. The pin was cut short. Closure was performed in layers. Post-operative radiographs were taken which showed good alignment of the tarsal joints and good placement of the implants. A Modified Robert Jones splint bandage was placed on the limb and the recovered well from anesthesia. Post-op radiographs were taken and revealed a successful surgery.

7. The dog was administered Cefazolin 100mg/mL, 6.8mL IV intra-op and Convenia 80mg/mL, 2.5mLs was administered post-op. The dog was started on a liter of NaCl with 3.74mLs of butorphanol 10mg/mL at a rate of 60mL/hr.

8. Respondent contacted Complainant post-surgery to give her an update on the dog. He reported that the surgery was successful, with the affected joint being drilled out and stabilized with a large pin and a stabilizing orthopedic wire. The dog will need a bandage for at least 2 – 3 weeks if tolerating well. IV pain medication was to be continued overnight and the dog would be able to be discharged the next evening. Discharge instructions were prepared for Complainant regarding the dog's aftercare including activity restrictions, bandage care and expectations for changes and radiographs in the coming weeks.

9. The following day, the dog was monitored throughout the day; was eating and drinking well. The dog was discharged later that evening with the following:

a. Carprofen 100mg, 14 chewables; give ½ tablet by mouth every 12 hours as needed for pain; and
b. Trazodone 100mg, 20 tablets; give ½ - 1 tablet by mouth every 8 – 12 hours as needed for anxiety.
c. Tramadol – declined.

10. On December 20, 2018, the dog was presented to Respondent for a recheck and bandage change. Upon exam, the dog had a weight = 47.10 pounds; no temperature, pulse or respiration noted. The dog was BAR, removal of the bandage showed a healing surgical and bone graft incisions. There was moderate redness around the surgery incision and moderate scabbing – no evidence of dehiscence. Respondent noted several areas of early/mild pressure sore formation but nothing significant at that time. Also noted was a small section of necrotic skin directly over the proximal extent of the calcaneus. The proximal intertarsal joint was stable on palpation with no significant discomfort. The bandage was replaced after cleaning the incisions and surrounding skin. A Telfa pad and silver sulfadiazine was placed on incision. Complainant was instructed to continue restricting the dog's activity and return in a week for a bandage change. A prescription for Tramadol was provided.

11. On December 27, 2018, the dog was presented to Respondent for a bandage change. Respondent documented that the leg was healing well and staples were removed. The leg was resplinted and the dog was discharged with instructions to return in one week.

12. On December 31, 2018, Complainant called TSVC to report the dog was able to remove the bandage. Complainant asked if she could replace it herself and bring the dog in the following day. Staff advised not to replace the bandage; keep the dog confined and bring her in as soon as possible.

13. On January 3, 2019, it is noted in the medical records that the bandage was removed and to recheck in 2 weeks.

14. On January 8, 2019, the dog was presented to TSVC and was evaluated by EJR (Dr. Roberts?) due to Complainant's concerns with the dog's tarsal pad. The dog was still not weight bearing on the left hind leg. Dr. EJR noted avascular necrosis of the left tarsal pad, with exposure of deep tissue and ligamentous structures; no bandage was in place and incision was within normal limits. EJR recommended debridement to remove devitalized tissue, ozone flush and bandage. Complainant approved. After the procedure, a bandage was applied and Complainant was instructed to return the following day for a recheck. It was also recommended to follow-up with Respondent to determine if further surgery was required. The dog was discharged and Trazodone refilled.

15. On January 9, 2019, the dog was presented to TSVC for a recheck and bandage change. Respondent was not available (?) therefore the bandage was changed by a doctor at TSVC. It was noted that granulation tissue was forming but the bandage was seeped through with mild purulent discharge and blood. The area was cleaned and the bandage was replaced.

16. On January 10, 2019, the dog was presented to Respondent for a recheck exam. No weight, temperature, heart rate or respiration rate was noted. The bandage was removed and revealed a raw but healing wound centered around the tarsal pad. Tissue condition was fair but improving. Proximal intertarsal joint stability is good and the proximal end of the pin was poking through the skin over the calcaneus.

17. Respondent's assessment was that the wound was likely secondary to self-trauma as it did not appear until the week after the splint bandage was removed. Elizabethan collar effectiveness needed improvement and the area required bandaging for protection. The leg was cleaned and dried and the bandage was replaced. Complainant was to return in one week.

18. On January 17, 2019, the dog was presented to TSVC for a recheck. The bandage was removed and it was noted that the pin was exposed at the dog's hock. Respondent was contacted via phone and it was determined the pin should be removed under sedation. The dog was sedated with dexdomitor, the pin was removed and it was noted that the pad site was healing well with healthy granulation tissue. The dog's leg was re-splinted per Respondent's instructions and Complainant was to return in 3 – 4 days for replace the splint with a soft bandage. Respondent would then recheck the dog 3 days after that.

19. On January 21, 2019, the dog was presented to TSVC for a recheck and bandage change. The bandage was removed and it was noted that the carpal pad was completely healed and sutures were removed. There was a cerclage wire exposed on the calcaneus. A bandage was replaced and Complainant was instructed to recheck in a couple days with Respondent. Carprofen and Trazodone was refilled.

20. No documentation noting the dog was seen by Respondent a couple days later.

21. On January 31, 2019, the dog was presented to TSVC due to the dog removing the bandage. The dog was weight bearing slightly and Complainant was walking slowly with her. The doctor on staff applied a splint to the leg per Respondent's instructions to stabilize and reduce motion. Complainant was instructed to return in one week to see Respondent.

22. On February 7, 2019, it is noted in the medical record that per Respondent they would be leaving the bandage off; restrict activity and recheck in 2 weeks. Trazodone was refilled.

23. On February 21, 2019, the dog was presented to Respondent for a recheck. Upon exam, the dog had a weight = 51.1 pounds, a temperature = 100.3 degrees, a heart rate = 134bpm and a respiration rate = 44rpm. It was noted that the soft tissue injuries from splinting were resolving but there was a raw spot on the medial surface of the second digit, likely from placing excessive pressure on the medial paw surface during ambulation. Respondent noted some instability at the previous injured joint that had developed, however, the limb seemed comfortable.

24. Respondent's assessment was that the arthrodesis had not fully fused as a result of the early movement of the pin and severe soft tissue splint reaction leading to the need for early removal. Use of the limb was likely to continue to improve but if the affected joint fully collapsed, surgery may need to be repeated. Complainant was instructed to continue to allow the dog to walk, but no running or jumping. Complainant was to keep Respondent posted on the dog's status via text.

25. On February 25, 2019, Complainant reported the dog was doing well but was trying to jump on the bed and stand on her back legs.

26. On February 27, 2019, Complainant reported that while out for a walk, she and the dog were chased by javelinas, therefore the dog was forced to run. However, the dog was using all four limbs and appeared to be walking fine afterwards. Tramadol had been discontinued and Carprofen was being administered as needed.

27. On March 5, 2019, Complainant reported that the dog was doing well and did have a slight limp. Complainant thought it could be due to the portion of the pad that needed to be removed.

28. On March 15, 2019, Complainant relayed that the dog continued to limp on occasion and was hopping less. Complainant was administering Carprofen as needed.

29. On March 23, 2019, Complainant reported the dog was hopping less but would stand

without putting weight on the leg. She felt it was possibly due to increased activity.

30. On March 28, 2019, Complainant relayed that when the dog was vaccinated they were told the dog had a heart murmur. Complainant requested Respondent listen to the dog's heart for a second opinion when he saw the dog again.

31. On April 1, 2019, the dog was presented to Respondent for a recheck. No weight, temperature, heart rate or respiration rate was noted in the medical record. No mention of the dog's possible heart murmur. Respondent documented that the dog was walking well on the surgical leg. There was still a small opening over the calcaneus where the previous deep pressure sore was during the bandaging. The main metatarsal pad was mostly gone but there was some secondary callus forming in the area. Stability of the intertarsal joint was good on palpation. The residual drainage from the gradually healing pressure sore may represent a nidus of deep infection and should be treated again. Respondent recommended continuing to add to the dog's activity and he called in a prescription for a month's worth of Ciprofloxacin 500mg, 30 tablets; give one tablet orally every 24 hours.

32. In April Complainant moved to Colorado; she reported the dog was getting around well but had a blister that continued to form on her heal.

33. On October 10, 2019, the dog was presented to Dr. Miller at Colorado Canine Orthopedics & Rehab due to worsening lameness and the dog's subsequent refusal to use the limb. There were also reports of periodic drainage from small sores at the calcaneus.

34. Dr. Miller's obtained radiographs that revealed proximal intertarsal instability with hyperextension occurring. There was an orthopedic wire present in the soft tissues of the calcaneus. No significant callus formation was visible at the proximal intertarsal joint. There was failure of the previous arthrodesis attempt.

35. Dr. Miller reviewed the pre-op and post-op radiographs of the dog. He advised Complainant that failure to achieve union in an arthrodesis was a potential complication and this failure did not necessarily indicate incorrect treatment. However, he had some concerns about a few technical aspects of the surgery:

a. The tension band placement was atypical. Generally it is placed to fight bending forces on the pin and in this situation would be placed between the calcaneus and 4th tarsal bone. In the position it was placed, it was not fighting any bending forces at the location of the luxation. Also, on post-op radiographs, it did not engage any bone even at the location it was placed;
b. The primary pin had limited engagement distal to the luxation; and
c. There was no visible callus on the 1-year-old post-op radiographs. In most failed arthrodesis, Dr. Miller saw significant callus formation with lack of actual bridging. In this case, he did not see callus formation which made him concerned there may not have been debridement. At the time of revision surgery, quite a bit of cartilage was present in the joint. Without seeing the surgery report from the original surgery, Dr. Miller could not know whether the cartilage debridement was performed, but if it was not, that would be an unusual execution of an arthrodesis.

36. Dr. Miller stated that he performed a revision surgery with cartilage debridement, grafting, and plate placement. The orthopedic wire from the previous surgery was removed and cultured; MRSP was present on the culture.

37. Complainant did not feel Respondent properly performed the partial tarsal arthrodesis due to the surgery failing and needing a revision surgery.

38. Respondent stated that a sound decision was made in the choice of surgical technique and the technique was performed properly. Additionally, Respondent felt that the many complications that arose were likely worsened by client compliance issues.

COMMITTEE DISCUSSION:

The Committee discussed that they had concerns Respondent left the cerclage wire in the dog's leg when there was a draining tract present; a culture was not obtained.

There were two questions of concern: 1) was the entire proximal intertarsal joint unstable or not – after reviewing the radiographs, it appeared that the entire proximal intertarsal joint was unstable at the initial surgery, but cannot be proven. Respondent felt that just the one joint was affected therefore 2) was the surgery approach appropriate for the injury the dog had. Respondent performed a surgery that is described in literature and when fixation is applied appropriately, it should stabilize the joint.

In this case, the cerclage wire that was placed was not appropriately applied; the fixation was not where it should have been. Respondent responded yes when asked if he was satisfied with the fixation post-operatively – this further concerned the Committee. The fixation not being applied appropriately likely played a significant role in the failure of the surgery. The cerclage wire should have engaged bone at some point, and it never did, according to the radiographs reviewed. It should have engaged bone way below where it was placed, but even where it was placed, it did not engage bone. Therefore the cerclage wire, in addition to the pin, could not provide enough stability, even if the cartilage was drilled out and bone graft placed.

The pin was generally placed correctly and was engaged enough to do its job if the cerclage wire had been placed appropriately. The Committee commented that if the incorrect placement of the cerclage wire was identified on the post-op radiographs, there could have been an opportunity to go back in and correct the error.

COMMITTEE'S PROPOSED CONCLUSIONS of LAW:

The Committee concluded that possible violations of the *Veterinary Practice Act* occurred.

COMMITTEE'S RECOMMENDED DISPOSITION:

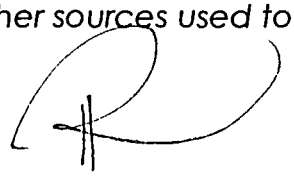
Motion: It was moved and seconded the Board find:

ARS § 32-2232 (22) Medical incompetence in the practice of veterinary medicine due to improper placement of cerclage wire and incorrect radiograph interpretation of the

post-op radiographs on December 13, 2018; not recommending removal of the cerclage wire that was serving no purpose when a draining tract was present on April 1, 2019; and not performing a culture.

Vote: The motion was approved with a vote of 5 to 0.

The information contained in this report was obtained from the case file, which includes the complaint, the respondent's response, any consulting veterinarian or witness input, and any other sources used to gather information for the investigation.



Tracy A. Riendeau, CVT
Investigative Division

DOUGLAS. A DUCEY
GOVERNOR

VICTORIA WHITMORE
EXECUTIVE DIRECTOR

ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD

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IN ACCORDANCE WITH § A.R.S. 32-2237(D): "IF THE BOARD REJECTS ANY RECOMMENDATION CONTAINED IN A REPORT OF THE INVESTIGATIVE COMMITTEE, IT SHALL DOCUMENT THE REASONS FOR ITS DECISION IN WRITING."

At the June 17, 2020 meeting of the Arizona State Veterinary Medical Examining Board, the Board conducted an Informal Interview in Case 20-44, In Re: William Linney, DVM.

The Board considered the Investigative Committee Findings of Fact, Conclusions of Law, and Recommended Disposition:

> *ARS § 32-2232 (22) Medical incompetence in the practice of veterinary medicine due to improper placement of cerclage wire and incorrect radiograph interpretation of the post-op radiographs on December 13, 2018; not recommending removal of the cerclage wire that was serving no purpose when a draining tract was present on April 1, 2019; and not performing a culture.*

Following the informal interview with Respondent, the Board found Respondent explanation of the surgery and aftercare and treatment credible and voted to disagree with the Investigative Committee's recommendation and dismiss this issue with no violation.

Respectfully submitted this 15TH day of July, 2020.

Arizona State Veterinary Medical Examining Board

Jim Loughead, Chair